The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.myisashealth.com or by calling 1-877-220-2514. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.myisashealth.com or by calling 1-877-220-2514 to request a copy.

Important Questions	Answers				Why This Matters:
What is the overall deductible?		**Network**		**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
		Standard	Healthy Choice Incentive		
	Per participant	$1,500	$1,250	$4,000	
	Per family	$3,750	$3,125	$10,000	
Are there services covered before you meet your deductible?	**Yes**. Preventive care, services that require co-payments (other than prescription drugs, see specific Rx deductible), and services listed below as No Charge.				This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes**. Prescription Drug ("Rx") Deductible				You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
		Network		**Non-Network**	
		Standard	Healthy Choice Incentive		
	Per participant	$125	None	$125	
What is the out-of-pocket limit for this plan?		**Network**		**Non-Network**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
		Standard	Healthy Choice Incentive		
	Per participant	$7,150	$6,250	Not Applicable	
	Per family	$14,300	$12,500	Not Applicable	

* For more information about limitations and exceptions, see the plan or policy document at www.myisashealth.com.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and penalties for failure to provide notification or obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes, for medical:** Blue Cross Blue Shield PPO. For a list of preferred providers, call 1-877-220-2514 or visit http://provider.bcbs.com/. **Yes, for prescription drugs:** Caremark. For a list of retail and mail pharmacies, log on to www.caremark.com.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider (Standard)	Your Cost If You Use an In-network Provider (Healthy Choice Incentive)	Your Cost If You Use an Non-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-payment/visit	$20 co-payment/visit	50% co-insurance	Includes lab, x-ray, and diagnostic test performed in office.
	Specialist visit	$60 co-payment/visit	$40 co-payment/visit	50% co-insurance	**Chiropractic Calendar Year Maximum:** 52 visits. After the first 24 visits, the Plan will only cover medically necessary chiropractic services.
	Preventive care/screening/ immunization	No Charge	No Charge	50% co-insurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	25% co-insurance	15% co-insurance	50% co-insurance	Lab, x-ray, and diagnostic tests performed in the office will be covered under the office visit benefit.
	Imaging (CT/PET scans, MRIs)	25% co-insurance	15% co-insurance	50% co-insurance	**Pre-certification is required**. Penalty of $250 in-network or $750 out-of-network will apply.

Common Medical Event	Services You May Need	Your Cost If You Use an			Limitations, Exceptions, & Other Important Information
		In-network Provider		Non-Network	
		Standard	Healthy Choice Incentive		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	**Retail:** $15 co-payment **Mail Order:** $37.50 co-payment	**Retail:** $10 co-payment **Mail Order:** $25 co-payment	**Retail:** 50% co-insurance **Mail Order:** Not Covered	**Retail:** 30 days **Mail Order:** 90 days Prescription benefits apply after the Prescription Drug deducible has been met. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.caremark.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. When a generic drug is available, but the provider indicates a brand name drug is necessary or the member requests the brand name alternative, the Plan will cover the cost of the generic level only. The difference between the cost of the brand and generic will be the member's responsibility.
	Preferred brand drugs	**Retail:** $40 co-payment **Mail Order:** $100 co-payment	**Retail:** $30 co-payment **Mail Order:** $75 co-payment	**Retail:** 50% co-insurance **Mail Order:** Not Covered	
	Non-preferred brand drugs	**Retail:** $80 co-payment **Mail Order:** $200 co-payment	**Retail:** $60 co-payment **Mail Order:** $150 co-payment	**Retail:** 50% co-insurance **Mail Order:** Not Covered	
	Specialty drugs	25% co-insurance	15% co-insurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% co-insurance	15% co-insurance	Not Covered	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
	Physician/surgeon fees	25% co-insurance	15% co-insurance	50% co-insurance	
If you need immediate medical attention	Emergency room care	$200 co-payment/visit	$175 co-payment/visit	**Standard:** $200 co-payment per visit **Healthy Choice:** $175 copayment per visit	Co-payment is waived if the patient is admitted into the hospital.

Common Medical Event	Services You May Need	Your Cost If You Use an			Limitations, Exceptions, & Other Important Information
		In-network Provider		Non-Network	
		Standard	Healthy Choice Incentive		
If you need immediate medical attention	Emergency medical transportation	$50 co-payment/ transport	$50 co-payment/ transport	$50 co-payment/ transport	Emergency transportation is available by ground, air, or water to the closest hospital that offers appropriate emergency care.
	Urgent care	$100 co-payment/ visit	$75 co-payment/ visit	50% co-insurance	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% co-insurance	15% co-insurance	Not Covered	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
	Physician/surgeon fees	25% co-insurance	15% co-insurance	50% co-insurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 co-payment/ visit	$20 co-payment/ visit	50% co-insurance	——————————none——————————
	Inpatient services	25% co-insurance	15% co-insurance	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
If you are pregnant	Office visits	$30 co-payment for initial office visit only	$20 co-payment for initial office visit only	50% co-insurance	Cost sharing does not apply for preventive services. Depending on the type of services, co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **Pre-certification is required** for in-patient stay over 48 hours for vaginal delivery or 96 hours for caesarian delivery. Penalty of $250 in-network or $750 out-of-network will apply.
	Childbirth/delivery professional services	No Charge	No Charge	50% co-insurance	
	Childbirth/delivery facility services	25% co-insurance	15% co-insurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	25% co-insurance	15% co-insurance	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply. **Calendar Year Maximum:** 120 visits.
	Rehabilitation services	25% co-insurance	15% co-insurance	50% co-insurance	Must be goal-directed rehabilitation. **Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.

Common Medical Event	Services You May Need	Your Cost If You Use an			Limitations, Exceptions, & Other Important Information
		In-network Provider		Non-Network	
		Standard	Healthy Choice Incentive		
If you need help recovering or have other special health needs	Habilitation services	25% co-insurance	15% co-insurance	50% co-insurance	Must be goal-directed habilitation. **Pre-certification is required. Penalty of $250 in-network or $750 out-of-network will apply.** **Calendar Year Maximum:** 24 visits
	Skilled nursing care	25% co-insurance	15% co-insurance	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply. **Calendar Year Maximum:** 100 visits
	Durable medical equipment	25% co-insurance	15% co-insurance	50% co-insurance	**Pre-certification is required** on equipment over $500. Penalty of $250 in-network or $750 out-of-network will apply.
	Hospice services	25% co-insurance	15% co-insurance	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Vision coverage is a separate election.
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Dental coverage is a separate election.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Weight loss programs (Naturally Slim for metabolic syndrome)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-800-920-7237. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
You may also contact the Care Coordinator to assist the plan administrator. The Care Coordinator's name, address, and telephone number are:

Quantum Health Inc.
Attention: Appeals
7450 Huntington Park Drive, Suite 100
Columbus, OH 43235
1-877-225-2981

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-225-2981.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-225-2981.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-225-2981.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-225-2981.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist co-payment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$100
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,800**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist co-payment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist co-payment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The maternity coverage example assumes the baby is enrolled in the Plan. These examples reflect a member enrolled in the Standard benefits. A member receiving the Healthy Choice Incentives may have lower costs. For more information about the Healthy Choice Wellness Program, please contact your Care Coordinator at 1-877-220-2514.

The plan would be responsible for the other costs of these EXAMPLE covered services.